Fall/Winter 2000-2001

In this issue:

California Partnership News

A Program of The California Department of Health Services

Sandra Pierce-Miller

Message From The Project Director

The Partnership took to the road with agent seminars and marketing roundtable discussions earlier this year, conducting five seminars throughout California over two weeks. I had the pleasure of meeting nearly 700 Partnership long-term care insurance agents in Woodland Hills, Anaheim, San Diego, Sacramento and Oakland. Your reception was warm and your enthusiasm for the Partnership product was evident.

We designed the agent seminars and roundtable discussions to help agents more fully understand all aspects of the Partnership long-term care insurance product and how the Partnership program works together with other California Department of Health Services (DHS) programs. DHS and long-term care industry experts made presentations on a variety of long-term care issues. The marketing roundtables afforded agents the opportunity to ask questions of some of the top producers in Partnership policy sales and to learn about proven successful marketing strategies.

We've devoted this issue of *Partnership News* to the subjects covered at the agent seminars. In this newsletter you will find information on the care management and claims administration process, Medi-Cal eligibility and estate recovery, nursing home licensing and certification, Medi-Cal scope of coverage and the scope of services provided in long-term care facilities.

We hope to give you a more thorough understanding of the Partnership program, our relationship with Medi-Cal and other long-term care issues. Together, we will work to meet the long-term care needs of Californians and to be better prepared to answer their questions about long-term care. Thank you for your continued support of the Partnership program.

Care management: A forgotten benefit

One of the major benefits in all Partnership policies is care management, or care coordination, to help your clients plan and secure the long-term care services they need. Care management is a multi-step collaborative process designed to meet all of your client's long-term care needs – health, safety and social. Care management links your client to a full range of services using all available funding sources while promoting quality cost-effective outcomes. Most importantly, care management involves facilitation of care choices and supports the basic belief that your clients should have the right to participate in decisions affecting their lives.

One of the goals of the agent seminars was to help agents understand the care management process and how care management coordinates with claims administration. Speakers included representatives from Partnership care management organizations and partner companies.

Roy Christenson, Assistant Vice President of the Claims Department of Bankers Life and Casualty, shared the true story of a policyholder with agents at the seminars.

In this case, the care management process began when a claims administrator at our partner company was notified of a potential claim for a policyholder, a 78-year-old woman, by a member of her family. The policyholder had suffered a stroke and was in the hospital. Once the claims administrator determined that the woman held a comprehensive Partnership policy, the claims department sent a referral to a Partnership-approved care management agency to request an assessment of the policyholder. The woman, who had been discharged from the hospital to a skilled nursing

see Care Management, p.5

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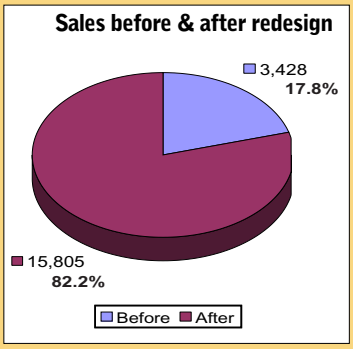
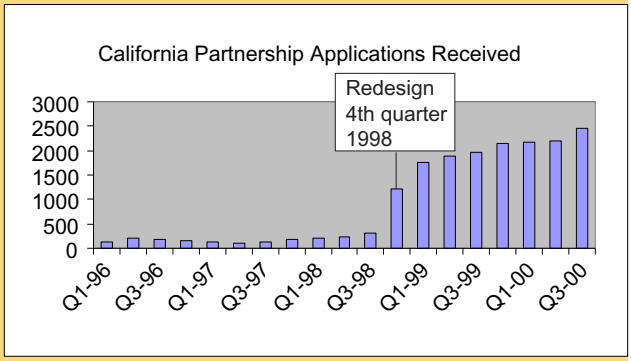
Sales Update & Profile of Buyer

The new and improved Partnership policies continue to post quarterly sales gains since their introduction in the 4th quarter of 1998. The 3rd quarter of 2000 has registered a 12% gain over the sales of the 2nd quarter of 2000 and a 25% gain over the sales of the 3rd quarter of 1999. Overall, 15,805 policies have been sold since redesign. This represents 82.2% of all policies sold since the programs' inception, for a total of over 19,233 policies sold.





Who is buying Partnership policies?

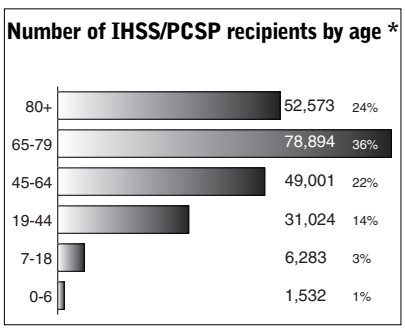
In the 3rd quarter of 2000:

- The median age of the purchaser is 63
- 59% of purchasers are female
- 66% are married
- 91% bought comprehensive policies
- 93% were 1st time purchasers
- 16% of purchasers bought one-year policies
- 19% of purchasers bought two-year policies
- 19% of purchaser bought three-year policies

Medi-Cal coverage includes long-term care alternatives

At the agent seminars, some agents were surprised to learn about several Medi-Cal long-term care benefits that provide alternatives to institutional care. The services are available through the California Department of Health Services Medi-Cal Home and Community Based Services Waivers Program, the California Department of Aging (CDA) and the In-Home Support Services (IHSS)/Personal Care Services Program (PCSP) offered by local social services departments.

The Home and Community Based Services Waivers program and the CDA offer four different waiver programs. This way, the state can add in-home services for long-term care needs not originally included in the State Plan for Medi-Cal. Today, 13,545 Californians receive long-term care through the waiver programs.



The Medi-Cal In-Home Operations Program provides Medi-Cal beneficiaries with medically-necessary long-term care nursing services in the home through the In-Home Medical Care waiver (IHMC), Nursing Facility waiver (NF) and Model Nursing Facility waiver (MNF).

The Multipurpose Senior Services Program waiver (MSSP), which the CDA administers, arranges for and monitors the use of social and health community services for elderly clients who wish to remain in the community. The program offers transportation, adult social day care, meals, housing assistance, protective services, chore and personal care assistance and other services.

The 58 county social service agencies administer the IHSS/PCSP program, which the California Department of Social Services (DSS) oversees.

These two programs help over 200,000 eligible aged, blind and disabled individuals who would otherwise be unable to remain safely in their own homes.

Those who are eligible for services through the IHSS/PCSP program can receive as much as 283 hours of care at home per month. They can hire anyone to provide the care, including family members.

The services available through IHSS/PCSP include non-medical personal care, domestic and related services, heavy cleaning, protective supervision (IHSS only), transportation and para-medical services. The state pays over $79 million per month for these programs.

Clients who want more information on the eligibility requirements and the services offered by IHSS/PCSP can contact their local IHSS offices, listed in the phone book under the county welfare

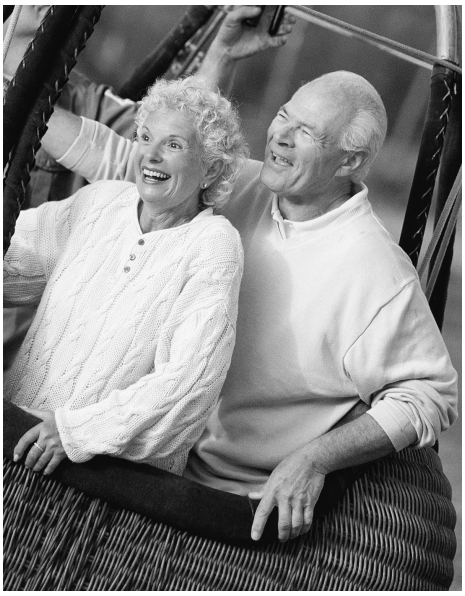
see Medi-Cal, p. 5

L&C keeps consumers safe

At the recent agent seminars, Diane Ford, Chief of the California Department of Health Services Licensing and Certification Field Support Branch, and John Hagerty, Chief of the Southern California L&C Field Branch, discussed their program's efforts to license and certify the state's health facilities and providers.

One of the L&C program's major activities is to license over 30 different types of health facilities and providers in California, amounting to more than 6,000 such facilities and providers. Of these, over 1,400 are licensed as skilled nursing facilities, which must meet stringent regulations outlined in the California Health and Safety Code and the California Code of Regulations. These are online at www.leginfo.ca.gov (go to Health and Safety Code, Division 2, Chapter 2, Sections 1250-1262 and Division 2, Chapter 2.4, Sections 1417-1439.8) and ccr.oal.ca.gov (click on California Code of Regulations, go to Title 22, Division 5).

L&C also certifies to the federal government that nursing facilities are eligible for Medi-Cal and Medicare payments. Although the federal Health Care Financing Administration (HCFA) is primarily responsible for overseeing skilled nursing facilities, L&C works with HCFA to implement and enforce the federal mandate (Code of Federal Regulations, Title 42, Part 483). Under the state's contract with HCFA, surveyors from the L&C program make certification visits to every newly-licensed nursing facility that wants to participate in Medicare or Medi-Cal. L&C makes sure the facility complies with federal care requirements for participation in either program. Of the nursing facilities in California, almost 88 percent receive payment under one or both of these programs.



A team of two to five of the 600 surveyors employed by L&C conducts each survey. Team size varies depending on the size of the facility, the purpose of the survey and the compliance history of the facility. Over 90 percent of the surveyors are nurses. Other surveyors may include pharmacists, nutritionists, occupational therapists, physical therapists, physicians or infection control specialists.

L&C surveyors then reinspect a facility annually, allowing no more than 15 months between surveys. HCFA renews certification only if the facility has maintained substantial compliance with statutes and regulations. The goal of the rigorous survey is to review a facility's plans, policies, procedures and activities to ensure that the facility complies with federal and state statutes and regulations to maintain the quality of life and quality of care for its residents.

Most nursing homes in California provide excellent care, so most of the problems the survey teams discover are small and easy to correct. Sometimes a survey reveals a facility that is substantially out of compliance with federal requirements. In these cases, L&C begins an enforcement process that depends on the severity and scope of the noncompliance. Remedies range from levying daily fines or denying payment if a facility does not take corrective action within a specified time to terminating the facility's participation in Medicare or Medi-Cal.

Continuing Education Information

These Continuing Education providers, approved by the Department of Insurance and the Department of Health Services, offer the training required by the Partnership.

The Partnership does not endorse any particular course, but all courses must follow the outline developed by the Partnership. Please call the providers below for their list of scheduled classes or visit their Web sites for detailed information.

Sandi Kruise
Sandi Kruise Insurance Training
1335 Hotel Circle South, Suite 306
San Diego, CA 92108
Tel. (800) 517-7500
Fax (619) 280-1857
www.kruise.com
Multiple instructors

Sandi Miley
Miley Education & Insurance
514 Via de la Valle, Suite 310
Solana Beach, CA 92075
Tel. (800) 296-8440
Fax (619) 793-8375
Single instructor

Tom Orr
Senior Insurance Training Services
1262 Broadway
Sonoma, CA 95476-9998
Tel. (800) 460-7487
Fax (707) 939-0489
www.tomorr.com
Multiple instructors

Key to L&C's regulatory and enforcement function is investigating consumer complaints about long-term care facilities, ensuring that nursing homes meet state and federal quality standards. Within ten working days of receiving a complaint, L&C begins an investigation. But if the complaint alleges an "immediate and serious threat" to the resident, the L&C team begins action within two working days of the complaint. Consumers can register complaints against

see L&C, p.7

Medi-Cal eligibility and estate recovery

At the agent seminars, California Department of Health Services experts Sharyl Shanen-Raya and Keith Parsley discussed Medi-Cal eligibility and estate recovery. Here are some of the questions that were asked most often during the seminars.

Q: Are the assets identified in a pre-nuptial agreement disregarded for the purpose of eligibility when an individual applies for Medi-Cal? What about estate recovery?

A: With a prenuptial agreement, the county considers the living situation of the individual at the time of application in order to determine Medi-Cal eligibility.

Let's take at look at three living situations:

Example #1: Both spouses are at home. All non-exempt property over $3,000 (including assets identified in a pre-nuptial agreement) is counted in determining Medi-Cal eligibility.

Example #2: Both spouses are in board & care *or* only one spouse is in board & care and one remains at home *or* both spouses are in long-term care. The property of the non-applicant spouse that is established as separate property in the pre-nuptial agreement (as long as it remains separate) is disregarded for purposes of establishing eligibility. Half of the community property is also disregarded.

Example #3: One spouse is at home or in a board & care facility. The other is in a medical institution or nursing facility and expected to remain for 30 days. All non-exempt property (including assets identified in pre-nuptial agreements) counts in determining eligibility. The couple is allowed to keep $86,120 in assets or the amount identified by court order or fair hearing, whichever is greater.

For purposes of estate recovery, in all of these examples the state can only make a claim against assets that pass from the deceased Medi-Cal beneficiary to his or her spouse (i.e., the community property interest in the assets) upon death. Any assets that pass to the surviving spouse before the death of the Medi-Cal beneficiary are not recoverable.

Q: Are assets my spouse inherits disregarded for eligibility purposes when I apply for Medi-Cal? For the purpose of estate recovery?

A: In the case of an inheritance, the assets disregarded for the purpose of determining eligibility are the same as those in a pre-nuptial agreement. The estate recovery program can only file claims against the assets that pass from deceased Medi-Cal beneficiaries to their surviving spouses upon death. Any assets that pass to the surviving spouse before the death of the Medi-Cal beneficiary are not recoverable.

Q: Are assets from a prior marriage exempt for eligibility purposes? What about estate recovery?

A: The term "exempt" applies to a "type" or "classification" of property given exempt status by statute or regulation. Assets from a prior marriage are not a type of property that is exempt. Property from a prior marriage may be considered separate property if it has not been combined with the property of the current spouse. If the property is separate property, it may or may not be counted, as in the living situations described above.

Estate recovery can file a claim against any asset (e.g., the community property interest) that passes from the deceased person to the surviving spouse upon his or her death. Estate recovery only takes place, however, when the surviving spouse dies.

Q: The institutionalized spouse has $200,000 of assets protected through a Partnership policy. The spouse at home gives $200,000 to a child on January 1, 1999, and applies for Medi-Cal on February 28, 2000. Is there a penalty under the rules for transfer of property?

A: In this example, assuming the couple has no other countable property (all they have is $200,000 in assets) at the time of the transfer, the transfer of the protected assets is considered a transfer of exempt property. Therefore, there is no period of ineligibility for nursing facility level of care.

This above exemption only applies during the lifetime of the institutionalized spouse for eligibility purposes. After the institutionalized spouse dies, this exemption no longer applies. For estate recovery purposes, however, the $200,000 of asset protection continues even after the death of the protected spouse.

Q: Is there such a thing as a "Medi-Cal-friendly annuity?"

A: There is no such thing as a Medi-Cal-friendly annuity. The balance of an annuity is considered unavailable as long as the owner receives equal monthly payments for a number of years, less than or equal to life expectancy (based upon life expectancy tables designated by Health Care Financing Administration for this purpose). The final payment may be smaller to exhaust the annuity. If payments are not equal and monthly, the cash surrender value is counted. If payments extend beyond life expectancy, a period of ineligibility for nursing facility level of care may result.

Some annuities pay very small amounts, with a balloon payment at the end. These annuities, even though set up to exhaust within life expectancy, are not annuitized in accordance with DHS rules. The cash surrender value is counted in determining eligibility. In many cases, these annuities are irrevocable and do not have a cash value and there is nothing to count. Individuals who purchase this type of annuity lose financial control while cashing in their

see Q&A, p. 7

Care management (continued from p. 1)

facility for physical and occupational therapy, was assessed by a care manager who looked at the woman's social, physical, emotional and cognitive strengths and deficits. The assessment included a look at the woman's family and support system, financial status and living arrangements as well.

The results of the assessment revealed that the woman was not only partially paralyzed by the stroke but was blind as well. The care manager forwarded this information to the claims administrator.

The family member who notified the partner company of the woman's situation thought that the policyholder should continue to receive assistance in a residential care facility. Although the woman was blind, she had always been self-sufficient and lived independently, and she wanted to live at home while recovering from her stroke.

The care manager developed an individualized plan of care in conjunction with the insurance company's claims administrator and the family. Their goal was to help the woman get the care she wanted and needed in order to remain at home.

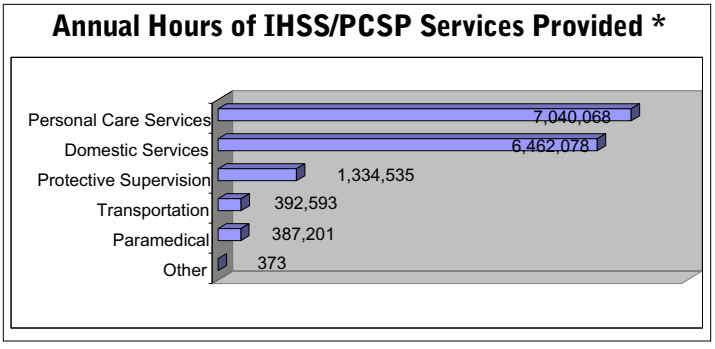
The care manager gathered and coordinated services in the woman's community, combining multiple-payer sources and maximizing the policy benefits with informal and formal care. The plan of care included help with transportation, housekeeping, bathing, dressing, and meals, as well as providing companionship for the woman.

The claims administrator ensured that the woman was receiving appropriate cost-effective benefits through the plan of care, and the insurance company paid for her care. The care manager's care coordination, as well as ongoing monitoring, helped the woman implement the plan of care.

Because of the care management offered in all Partnership policies, this policyholder can be assured that if she continues to need care and exhausts her benefits, her care manager will help her make a smooth transition to other payer sources, like Medi-Cal. The claims administrator will track the policyholder as she nears the point of exhausting her benefits and will work closely with the care manager to develop a discharge plan so she will have a reasonable treatment plan without the benefit of insurance payment. This is especially important if the policyholder has assets over and above what would be disregarded for Medi-Cal eligibility. At the time the policyholder applies for Medi-Cal, the Partnership will contact the county welfare office to ensure that the woman's assets are exempt from "spend-down."

Care management, along with a policy that offers interchangeable benefits and a "bucket of money," is of major value to the policyholder because it provides the opportunity to extend the insurance benefit with coordinated formal and informal care. Partnership-certified policies emphasize consumer choice and flexibility by enabling consumers to purchase an integrated "bucket of money" that can be spent either in the nursing home or at home with home health care. Consequently, if a claimant is able to save money on service costs through a cost-effective plan of care, his or her long-term care insurance benefits will stretch further. This will result in avoiding or delaying the need for Medi-Cal to fund long-term care.

Medi-Cal (continued from p.2)



**Source: Department of Social Services IHSS Statewide Summary Report, December 1998*

department in the County Government Section.

More information about the MSSP waiver program, including eligibility requirements, is available from the California Department of Aging at 1-800-510-2020 (only in California). This program currently is at full capacity.

For information on the other waiver programs (IHMC, NF, MNF), please direct clients to the California Department of Health Services, 916-324-1020. These three programs have limited enrollment capacity.

The long-term care continuum

Nearly one in two Americans age 65 and over can expect to spend some time in a nursing home. According to the Agency for Health Care Policy and Research as of January 1996, 1.6 million people were receiving care in approximately 16,800 nursing homes in the U.S. An estimated 5.6 million elderly will be in nursing homes by 2080.

Today there are many options for long-term care in a variety of settings – homes, community programs and nursing facilities. More options mean care in more appropriate settings, resulting in better outcomes and a higher quality of life.

Many agents have asked the Partnership about the institutional aspect of nursing facility care. At the agent seminars, local nursing facility administrators representing the California Association of Health Facilities and the California Association of Homes and Services for the Aging compared the different types of long-term care facilities.

SUB-ACUTE CARE

·Few facilities certified for this intensive, medically-complex care

·Nursing homes designated as either sub-acute or dementia facility

SKILLED NURSING

- Medical model for care and support – medical director on staff
- Includes nursing facilities, nursing homes and convalescent hospitals
- Resident typically frail elderly and over age 65 (average age is 85)
- Licensed by the Department of Health Services
- Provides:
  - ⇒ Support of chronic care conditions and short-stay rehabilitation
  - ⇒ Medical treatment under supervision of licensed nurses 24 hours a day
  - ⇒ Many medications, IV care, wound care
  - ⇒ Interdisciplinary assessment and care plan developed by professional staff and family
  - ⇒ On-site rehabilitation, physical, occupational, speech and respiratory therapy
  - ⇒ Dental, optometry, audiology and pharmacy services
  - ⇒ Hospice, respite or restorative nursing care
  - ⇒ Dementia and Alzheimer's care in addition to social and psychological services
  - ⇒ Daily activities and assistance with activities of daily living
  - ⇒ Dietary services, including special and modified diets

INTERMEDIATE CARE

- Step down from Skilled Nursing Care
- Lower staff-to-patient ratio
- Represents only a small part of the LTC continuum

RESIDENTIAL CARE

- Social model of care
- Known as assisted living, board and care, residential care facility or residential care facility for the elderly
- More independent activity and services to allow aging in place
- Regulated by Department of Social Services
- Not required to offer 24-hour nursing care
- No medical support services
- Provides:
  - ⇒ Supervision and limited assistance with ADLs
  - ⇒ Medication assistance
  - ⇒ Dietary services
  - ⇒ Rehabilitation therapy, usually contracted with home health agency
  - ⇒ Transportation
  - ⇒ Activities/social interaction programs
  - ⇒ Dementia/Alzheimer's programs
  - ⇒ Hospice
  - ⇒ Respite care
- Prohibited conditions: gastrostomy, tracheostomies, liquid oxygen, naso-gastric tubes, staph infection, dependence on others for all ADLs, need for 24-hour nursing care

RETIREMENT FACILITY

- Independent living
- Apartments
- Social activity
- Transportation

CONTINUING CARE RETIREMENT COMMUNITY(CCRC)

- A contract for the provision of care for more than one year
- Multi level of caregiving service on one campus
- Generally includes independent living, assisted living and nursing care
- Encourages aging in place by offering residents more services in same location for different levels of care
- Generally one time entry fee paid by applicant upon admission, plus monthly maintenance fee
- Licensed by Department of Social Services and/or Department of Health Services

LIFE CARE CONTRACT

- A subset of CCRCs
- Guarantee of routine services at all levels of care, including acute care and physicians and surgeons' services for the duration of individual's life
- No change made in the monthly fee based on level of service
- Assurance of guaranteed lifetime long-term care services regardless of financial ability to pay

HOME AND COMMUNITY BASED SERVICES

- Intent is to keep individual at home
- Includes:
  - ⇒ Adult day health care
  - ⇒ Hospice

see Continuum, p.8

Q&A (continued from p. 4)

life insurance policies, stocks, bonds, etc. Many times they have to pay heavy capital gains taxes and surrender penalties in the process.

Q: How are retirement annuities treated for Medi-Cal eligibility?

A: Annuities are not considered exempt unless they are IRAs, KEOGHs or work-related pension funds held in the name of a person who does not want Medi-Cal for him- or herself. If payments are being received, however, those payments are considered income.

The cash surrender value of IRAs, KEOGHs and work-related pension funds held in the name of an individual who does not want Medi-Cal is counted until the individual takes steps to receive either the cash lump sum or periodic payments of principal and interest. The periodic payments are considered income and the balance is considered unavailable.

Project Director Sandra Pierce-Miller addresses attendees at one of this year's agent seminars

L&C (continued from p. 3)

facilities by visiting, calling or writing to local L&C district offices. The address and telephone number for each district office is listed in the local telephone directory.

Recently, Governor Gray Davis approved legislation (Assembly Bill 1731, Chapter 451) to support his Aging With Dignity Initiative, which addresses issues related to aging, including nursing home reform. This initiative, effective January 1, 2001, directly affects L&C's oversight of nursing facilities in the state. The initiative funds an increase in unannounced inspections of nursing facilities, expansion of focused enforcement efforts, rapid response to complaints, increases in fines for serious or repeat violations and a wage increase for direct care staff. The initiative also creates a quality award under the L&C program for facilities that serve a high number of Medi-Cal patients while maintaining high-quality care and establishes a Fiscal Solvency Review Advisory Board to review and create new standards and reporting requirements for nursing facility licensees.

Through the efforts of the L&C program, thousands of Californians every day are ensured high-quality care in the state's nursing facilities. More information on the Department of Health Services Licensing and Certification program is available at www.dhs.ca.gov/lnc.

FAQs about patient transfer in and discharge from a nursing facility

Q: What percentage of nursing homes is Medi-Cal approved? Medicare approved?

A: Nearly 88% of the 1,400 nursing homes in California accept Medi-Cal:

- Title 18 only (Medicare): **8.3%**
- Title 18/19 (Medicare/Medi-Cal): **80.4%**
- Title 19 only (Medi-Cal): **7.3%**
- No Participation (licensed only): **4.0%**

Q: If a resident's method of payment changes from private payment or long-term care insurance payment to Medi-Cal payment, can the facility move the resident to another room in the facility?

A: Yes. A facility may move a resident from one bed in the facility to another bed *in the same facility*. Changes in rooms or roommates are allowed for any reason as long as the facility provides notice to the resident, the resident's physician and, if known, the resident's legal representative or interested family member.

In California, facilities may choose to certify a separate wing or section of their facility as a Medicare-distinct part. Under federal law, a resident may refuse a transfer from a distinct part of a facility to the part of the facility that is not a distinct part. If the resident refuses a transfer under this provision and the Medicare program will no longer pay for the resident's stay, the resident must either pay privately or arrange for Medi-Cal payment, if eligible.

Q: Can a certified facility designate certain beds as "Medi-Cal" beds? Is there such a thing as Medi-Cal-distinct part?

A: No. HCFA certifies facilities, not individual beds. A resident whose stay is being paid for by the Medi-Cal program can reside in any bed in the certified facility.

Q: Can a facility transfer or discharge a resident out of the facility because of a change in the resident's method of payment from private or long-term care insurance payment to Medi-Cal payment?

A: Generally, no. The only exception is if the facility is not certified to accept payment from the Medi-Cal program. In that case, the facility would be allowed to transfer or discharge the resident if the resident's stay is no longer covered by long-term care insurance and he/she is unable to continue to pay privately. However, the facility is required to inform residents of this possibility at the time they are admitted to the facility.

Continuum (continued from p.6)

⇒ Respite care
⇒ Home health
⇒ Personal care

Your clients can get help selecting a facility from a number of sources, including the CPLTC Web site, their local Area Agency on Aging, long-term care publications, the Internet, nursing home associations and professional care managers.

Source: California Association of Homes and Services for the Aging and California Association of Health Facilities

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For more information, call:
(916) 323-4253
(916) 323-4238 Fax
www.dhs.ca.gov/cpltc

Participating Insurers

Bankers Life and Casualty
(888) 2828-BLC

CNA Insurance
(800) 852-4414

GE Financial Assurance
(800) 354-6896

New York Life Insurance
(800) 224-4582

CalPERS Long-Term Care Program
(800) 205-2020

Transamerica Occidental Life Insurance
(800) 690-2758

Season's Greetings From the Partnership Staff

California Partnership News
A Program of The California Department of Health Services

In brief ...

WANTED!

Insurance professionals who have sold more than 20 CPLTC policies between January 1 and June 30, 2000. Call the Partnership office at (916) 323-4253 and give us your name and the number of policies you sold during these six months. Producers who respond will be recognized in the next issue of *Partnership News*.

CHANGE IN AVERAGE PRIVATE NURSING HOME DAILY COST

Preliminary calculations indicate that the average daily nursing home costs will increase to $140 in 2001. That means the minimum daily benefit for Partnership policies at 70 percent, rounded to the nearest $10 increment, will be $100. Look for more details in the upcoming *Issuers Bulletin* for 2001.

PARTNER NEWS

Project Director Sandra Pierce-Miller is pleased to announce that New York Life is now in the market with its redesigned Partnership policy.

PLEASE ACCEPT OUR APOLOGIES!

The Agent Seminar and Marketing Roundtable scheduled to take place in Fresno on April 18 was cancelled due to low enrollment. The Partnership will, however, hold two seminars in 2001 – one in Northern California and the other in Southern California. In the meantime, please contact the Partnership if we can help in any way.

AVAILABLE NOW FROM YOUR COMPANIES!

The Partnership's three consumer brochures can only be ordered from your company. If you have any problems getting the brochures from your company, please contact the Partnership and let us know.

SPECIAL OPPORTUNITY FOR PARTNERSHIP PRODUCERS

The Second Annual Southern California Long-Term Care Symposium will be held March 23 at the Anaheim Doubletree Hotel, presented by the American Association for Long-Term Care Insurance. Meet with top experts, visit exhibitors and more. You will be able to complete your four-hour Partnership re-certification course at no additional charge. Call (888) 599-5997 for a registration kit.

NEW INCOME AND RESOURCE AMOUNTS FOR COMMUNITY SPOUSES

California DHS's Medi-Cal Eligibility Branch has set the 2001 community spouse resource allowance (CSRA) at $87,000. The minimum monthly maintenance needs allowance (MMMNA) is $2,175 in monthly income for 2001.

Bulk Rate
U.S. Postage
PAID
Sacramento, CA
Permit No. 333